2017 Preliminary Filing Guidance

Filing Timeline

- The Evidence of Coverage (EOC) for each non-grandfathered individual and small group health product must be submitted via SERFF no later than February 1st – redlined version only
- A rate/form filing and binder must be submitted no later than May 1, 2016
- All carriers both on and off the Exchange must submit a binder for each market segment
- Binders must include validated plan management templates and network adequacy supporting data and documentation

NV Law Changes Impacting Plans

- **Assembly Bill 6**
  - Minimum coverage of the actuarially equivalent of $72,000 must be provided for autism
  - Establishes Registered Behavior Technician as new provider type
- **Assembly Bill 292**
  - Mandates telehealth for health and dental products
- **Senate Bill 67**
  - Renewal notices for individual health benefit plans that are not grandfathered must be delivered at least 30 days prior to open enrollment

NV Law Changes Impacting Plans

- **Senate Bill 137**
  - Establishes coordination of benefits rules for stand-alone dental plans and policies of health insurance
  - Stand-alone dental plans are primary for services provided by an oral and maxillofacial surgeon
- **Senate Bill 159**
  - Applies existing binding arbitration requirements for independent medical evaluations to dental care
- **Senate Bill 217**
  - Mandates coverage for early refills of topical ophthalmic products due to inadvertent wastage by patients
- **Senate Bill 250**
  - Mandates coverage for synchronized medication packs dispensed by a pharmacy

NV DOI Changes Impacting Plans

- **Regulation R049-14**
  - Establishes requirements related to the adequacy of provider networks
- **Regulation R074-14**
  - Prohibits changes to individual health drug formularies except under certain circumstances
- **Bulletin 15-002**
  - Clarifies that the denial, exclusion or limitation of medically necessary health care services on the basis of gender identity or expression is prohibited
- **Bulletin 15-007**
  - Clarifies that Nevada's definition of small employer will be 1-50 beginning January 1, 2016
  - Employee counting methodology based on full-time equivalent employees

2017 Nevada EHB Benchmark Plan

- HPN Solutions HMO Platinum 15/0/90%
- Plan includes embedded pediatric dental and vision consistent with NV CHIP and FEDVIP, respectively
- HPN actuarial equivalent substitutions for prior dollar limits become coverage floor
- Habilitation in parity with rehabilitation but combined limit not allowed in 2017
- Plan exclusionary language was effective 1/1/2014 and may no longer by compliant with state or federal rules

Federal Changes Impacting Plans

- **Notice of Benefit and Payment Parameters for 2016**
  - Combined habilitation and rehabilitation benefit limits prohibited effective 1/1/2017
- **Proposed Notice of Benefit and Payment Parameters for 2017**
  - Applies FFM QHP standards in SBMs using healthcare.gov
  - Applies network adequacy standards and other related requirements to SSBM states that do not implement an acceptable quantifiable network adequacy metric
  - Allows carriers to deny coverage for discontinued products after notice is delivered
  - Defines applicable rating area as employer's principal business address registered with the state, but, if for service of process and not a substantial worksite, then the business address with the greatest number of employees
  - Eliminates applicability of metallic levels to student health plans
  - Subjects student health plans to single risk pool index rating methodology

Federal Changes Impacting Plans

- **Proposed Notice of Benefit and Payment Parameters for 2017**
  - Redefines rate increase subject to review at the plan rather than product level
  - Requires all individual and small group issuers to submit URRT regardless of rate change requested
  - Creates re-enrollment hierarchal mapping criteria for exchange plans
  - Proposes to allow initial QHP premium payment as late as coverage effective date
  - Indexes MOOP for SADPs by applying CPI each year
  - Applies FFM QHP standards in SBMs using healthcare.gov
  - Imposes a healthcare.gov user fee on QHP issuers in SSBM states
  - Establishes “standardized options” on the individual exchange
  - Allows decertification of QHP if HHS reasonably believes issuer lacks the financial viability to provide coverage for remainder of year
  - Updated AV calculator

Federal Changes Impacting Plans

- **US DOL FAQs about Affordable Care Act Implementation and Mental Health Parity Implementation, October 23, 2015**
  - Carriers must provide access to lactation counseling providers within network
  - Breastfeeding equipment must be provided without cost sharing for the duration of breastfeeding
  - Carriers cannot impose cost sharing for consultation prior to colonoscopy
  - Pathology exam on a polyp biopsy must be covered without cost sharing
  - Genetic counseling and BRCA testing must be provided without cost sharing for women found to be at increased risk
  - Criteria for making medical necessity determinations must be disclosed upon request following prior authorization denial

NV Rate Review Process

- Only rate filings proposing a plan increase of 10% or more will be reviewed by external consulting actuaries
- Carriers will be required to submit utilization and cost data for benefit categories consistent with the latest version of Milliman's Health Cost Guidelines